Safer Care Victoria

Caring for people displaying acute behavioural disturbance

Clinical guidance supplement

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VICTORIA State Government

Contents

1. Guidance production process

TOPIC SELECTION

In 2018, Safer Care Victoria's (SCV) Emergency Care Clinical Network hosted a strategy day attended by more than 160 clinicians from across the emergency care sector. Attendees at this day identified improving the care of people displaying behaviours of concern as a priority focus area.

We subsequently formed a phase one expert working group to scope and prioritise improvement ideas. After reviewing literature, collecting data and consulting with Victorian healthcare stakeholders, one of the recommendations was to develop statewide evidence-based clinical guidance. The purpose of this guidance is to support person-centred, evidence-based practice and reduce unwarranted variation in care.

Scope

The guidance is intended for use by emergency care clinicians in Victoria. Table 1 describes the scope of the guidance.

Table 1: Scope of the clinical guidance

In scope	Out of scope
Adult patients (16–65 years of age)	Paediatric patients
Urgent care centres	Clear organic cause for acute behavioural disturbance (e.g. dementia, delirium, closed head injury)
Emergency departments	Care after discharge or transfer from an emergency department or urgent care centre
Transitions of care in and out of emergency departments or urgent care centres	Providing clinical guidance to Victoria Police
	Prehospital care*

* While out of scope, our guidance may be suitable to adapt.

EXPERT WORKING GROUP

We formed a phase two expert working group to develop the clinical guidance. The group, listed in Table 2, consisted of three healthcare consumer representatives, 13 clinical experts and two SCV staff members.

The Network's Governance Committee appointed the chair of the expert working group, and all other members were selected through an expression of interest process open for three weeks. Applicants were asked to submit one paragraph outlining why they were interested in being involved and any relevant experience or skills. All expressions of interest were reviewed by SCV staff and final membership of the group was endorsed by the working group chair and the Network clinical lead.

Table 2: Expert working group membership

Name	Role	Affiliation
Thomas Chan (chair)	Emergency Physician Director of Emergency Department	Austin Health
Kristy Austin	National Standards Accreditation Lead	Ambulance Victoria
Shaun Baxter	Emergency Physician Retrieval Physician	Alfred Health Adult Retrieval Victoria
Scott Bennetts	Manager, Clinical Practice Guidelines	Ambulance Victoria
Simon Craig	Emergency Physician	Monash Health
Sim Crawford	Consumer representative	Community
Jo Colvin	Emergency Department Alcohol and Other Drug Nurse Practitioner	Latrobe Regional Hospital
Dan Crompton	Emergency Physician Director of Emergency Services Retrieval Physician Director of Education and Training	Bass Coast Health (Wonthaggi Hospital) Adult Retrieval Victoria
John Cunning	Clinical Nurse Specialist (Psychiatry) Associate Director of Nursing	Benalla Health
Cathy Daniel	Consultation Liaison Nurse Coordinator of Postgraduate Mental Health Nursing	Royal Melbourne Hospital University of Melbourne
Claire Doherty	Project Lead, Emergency Care Clinical Network	Safer Care Victoria
Daniel Eltringham	Emergency Department Drug and Alcohol Care Coordinator	Bendigo Health
Liz Flemming-Judge	Consumer representative	Community
James Fowler	Clinical Fellow, Emergency Care Clinical Network	Safer Care Victoria
Kate James	Emergency Department Clinical Nurse Specialist	Werribee Mercy Hospital
Cristina Roman	Emergency Department Pharmacist	Alfred Health
Frances Sanders	Consumer representative	Community
Penny Whelan	Emergency Department Nurse Unit Manager	Goulburn Valley Health

Healthcare consumer involvement

Healthcare consumers are people, families and carers who are current or potential users of health services. All consumers included in our group have lived experience of behaviours of concern in emergency care settings.

All consumers were offered orientation to SCV and the Network and were reimbursed for their time and travel expenses. To support safe participation, consumers were given access to the Department of Health and Human Services (DHHS) employee assistance program. Consumers were also offered the opportunity to debrief with SCV staff and the working group chair after every meeting.

Conflicts of interest

Expert working group members were required to declare any conflicts of interest in a formal declaration when joining the group. No relevant conflicts were identified.

METHODOLOGY TO PRODUCE THE GUIDANCE

Production timeline

May 2019–April 2020.

Decision to endorse, adapt or develop

In line with SCV's evidence-based guidance strategy, we evaluated existing guidance relating to people displaying acute behavioural disturbance for applicability and methodological rigour. Shortlisted guidance was evaluated by at least two expert working group members. High-scoring guidance was evaluated by at least three members, including one consumer representative.

After evaluation we decided to adapt, with permission, the Alfred Health 'Physical and mechanical restraint: assessment and application guideline' for our 'Physical and mechanical restraint and ongoing care while restrained' section only.

Search method to review the evidence

We developed the guidance using a basic search strategy involving both a formal and informal approach. Evidence sources included academic literature, legislation, government documents and grey literature.

Databases searched

- EbscoHost: Academic Search Complete; Psych and Behavioral Science Collection; SocIndex
- OVID: MEDLINE; PsychInfo
- Scopus
- Cochrane Library
- INFORMIT: Health Collection; CINCH (Australian Institute of Criminology); FAMILY (Australian Institute of Family Studies); Humanities and Social Science Collection; Australian Policy Observatory
- Google Scholar

Keywords

Keywords used in the basic search strategy included: acute behavioural disturbance, aggression, agitation, assessment, behaviour of concern, behavioural escalation, best practice, clinical guidance, continuing care, critical care, debrief, de-escalation, difficult behaviour, discharge, distress, emergency, emergency department, framework, guideline, handover, incident, mental health, oncall GP, paramedic, policy, post-discharge, post-incident, post-sedation, prehospital, psychomotor agitation, referral, restraint, risk assessment, sedation, situational crisis, transfer, urgent care and violence.

Reviewed evidence

A bibliography of evidence the expert working group reviewed is included in Appendix 1. Not all reviewed evidence directly informed our guidance. We graded reviewed evidence according to the levels of evidence described in Table 3. These are based on the National Health and Medical Research Council's (NHMRC) 2009 levels of evidence and grades for recommendations for developers of guidelines. Note that the definitions for level V and consensus differ from that proposed by the NHMRC. The expert working group decided to introduce these levels of evidence to reflect the importance of lived experiences of care and consensus statements from respected authorities.

Table 3: Levels of evidence

Level	Description
I	Evidence obtained from a systematic review of all relevant randomised controlled trials
II	Evidence obtained from at least one properly designed randomised controlled trial
III-1	Evidence obtained from well-designed, pseudo-randomised controlled trials
III-2	Evidence obtained from comparative studies with concurrent controls, including reviews of such studies. Examples include cohort studies, case-control studies, non-randomised experimental trials, interrupted time series with a control group
III-3	Evidence obtained from comparative studies without concurrent controls, including reviews of such studies. Examples include historical control studies, two or more single-arm studies, interrupted time series without a parallel control group
IV	Evidence obtained from case series with either post-test or pre-test/post-test outcomes
V	Evidence obtained from single descriptive or qualitative studies, including reports of lived experiences of care
Consensus	Expert opinions based on respected authorities or reports of expert committees
N/A	Evidence that cannot be graded, such as legislation

Table 4 summarises the levels of evidence for each section of our guidance as an indication of what type of evidence was identified and reviewed.

Table 4: Level of evidence summary for each guidance section

	Level I	Level II	Level III-1	Level III-2	Level III-3	Level IV	Level V	Consensus	N/A
Assessment	1	0	0	6	2	0	9	18	0
Transition from prehospital care	0	0	0	0	0	0	1	0	1
De-escalation	5	0	0	0	2	0	7	8	0
Sedation and ongoing care post-sedation	1	6	0	6	1	4	0	6	0
Physical and mechanical restraint and ongoing care while restrained	3	0	0	2	10	1	12	4	0
Transition from the emergency care setting	0	0	0	0	0	0	1	0	1
After the person has left the emergency care setting	0	0	0	0	0	0	2	4	1

REACHING CONSENSUS

Consensus was reached among expert working group members through discussion, as summarised by the chair. Where consensus could not be reached on a matter, the chair could choose for it be decided by a simple majority vote, or by referral to the Network's Governance Committee for determination.

SCV staff members were responsible for the guidance creation process and for preparing the guidance supplement. They did not have casting votes for the purposes of consensus building or decision making in the group.

CONSULTATION

Public consultation

We performed a four-week open public consultation on our guidance in February 2020. This was an opportunity for individuals and organisations to have input into the content and structure of the guidance. Feedback was collected through an electronic survey accessible via the SCV website. A public consultation report is included in Appendix 2.

Targeted consultation

We performed a targeted, face-to-face consultation with the following organisations:

- DHHS mental health branch and lived experience workforce
- DHHS violence in healthcare reference group
- Australian Nursing and Midwifery Federation, Victorian branch
- Victorian Mental Health Complaints Commissioner.

REVIEW

In line with SCV's evidence-based guidance strategy, this guidance will be reviewed at least every five years, or more frequently if required, to reflect any changes in evidence and best practice. The latest possible review date is April 2025.

Feedback or changes in practice context in between scheduled revisions may prompt adjustments to the guidance. The decision to update the guidance in between scheduled review cycles will be made by the Network's Governance Committee in collaboration with previous expert working group members or topic experts as required.

The expert working group identified the following changes in practice context as possible triggers for review or adjustment to the guidance:

- changes to relevant legislation such as the *Mental Health Act 2014*
- sentinel events relating to care recommended in this guidance
- changes to statewide models of care for people displaying behaviours of concern, for example full implementation of the emergency mental health and alcohol and other drug (AOD) hubs.

FUTURE RESEARCH PRIORITIES

Based on their work producing this guidance, and their experience and knowledge, expert working group members identified the following future research priorities:

- determining the effectiveness of different de-escalation techniques, including when and with what types of people they should be used
- assessing any long-term effects of ketamine administration
- determining the most appropriate population for ketamine administration
- determining specific risks associated with different physical and mechanical restraint techniques, and the best technique to use with different populations
- establishing reliable reporting and auditable measures for the use of restrictive practices in emergency care settings.

2. Governance

APPROVAL

This guidance was approved by the Network's Governance Committee and SCV Centres of Clinical Excellence Director in April 2020.

FUNDING

No financial support was received to enable the development, publication and dissemination of this guidance.

Appendix 1: Reviewed evidence

Table A1: Levels of evidence

Level	Description
I	Evidence obtained from a systematic review of all relevant randomised controlled trials
II	Evidence obtained from at least one properly designed randomised controlled trial
III-1	Evidence obtained from well-designed, pseudo-randomised controlled trials
III-2	Evidence obtained from comparative studies with concurrent controls, including reviews of such studies. Examples include cohort studies, case-control studies, non-randomised experimental trials, interrupted time series with a control group
III-3	Evidence obtained from comparative studies without concurrent controls, including reviews of such studies. Examples include historical control studies, two or more single-arm studies, interrupted time series without a parallel control group
IV	Evidence obtained from case series with either post-test or pre-test/post-test outcomes
V	Evidence obtained from single descriptive or qualitative studies, including reports of lived experiences of care
Consensus	Expert opinions based on respected authorities or reports of expert committees
N/A	Evidence that cannot be graded, such as legislation

Assessment

Table A2: Level of evidence summary: assessment section

	Level I	Level II	Level III-1	Level III-2	Level III-3	Level IV	Level V	Consensus	N/A
Total number	1	0	0	6	2	0	9	18	0

Alam A, Rachal J, Tucci VT, Moukaddam N. Emergency department medical clearance of patients with psychiatric or behavioral emergencies, Part 2: Special Psychiatric Populations and Considerations. Psychiatric Clinics of North America [Internet]. 2017 [cited 2019];40(3):425–33.

Calver LA, Stokes B, Isbister GK. Sedation assessment tool to score acute behavioural disturbance in the emergency department. Emergency Medicine Australasia [Internet]. 2011 [cited 2019];23(6):732-40.

Considine J, Berry D, Johnson R, Sands N. Vital signs as predictors for aggression in hospital patients (VAPA). Journal of Clinical Nursing [Internet]. 2017 [cited 2019];26(17-18):2593–604.

Cowling SA, McKeon MA, Weiland TJ. Managing acute behavioural disturbance in an emergency department using a behavioural assessment room. Australian Health Review [Internet]. 2007 [cited 2019];31(2):296–304.

Douglass AM, Luo J, Baraff LJ. Emergency medicine and psychiatry agreement on diagnosis and disposition of emergency department patients with behavioral emergencies. Academic Emergency Medicine [Internet]. 2011 [cited 2019];18(4):368–73.

Downes MA, Healy P, Page CB, Bryant JL, Isbister GK. Structured team approach to the agitated patient in the emergency department. Emergency Medicine Australasia [Internet]. 2009 [cited 2019];21(3):196–202.

Garriga M, Pacchiarotti I, Kasper S, Zeller SL, Allen MH, Vazquez G, et al. Assessment and management of agitation in psychiatry: expert consensus. World Journal of Biological Psychiatry [Internet]. 2016 [cited 2019];17(2):86–128.

Goldberg RJ, Dubin WR, Fogel BS. Behavioral emergencies: assessment and psychopharmacologic management. Clinical Neuropharmacology. 1989;12(4):233–48.

Gottlieb M, Long B, Koyfman A. Approach to the agitated emergency department patient. Journal of Emergency Medicine [Internet]. 2018 [cited 2019];54(4):447–57.

Group PEW. Behavioural emergencies. Therapeutic guidelines: Psychotropic 7th edn. Melbourne: Therapeutic Guidelines Limited; 2013.

Hew R. Altered conscious state (Chapter 8.4). In: Brown AFT, Cameron P, Jelinek G, Kelly A-M, Little M, editors. Textbook of adult emergency medicine. Edinburgh; New York: Churchill Livingstone/Elsevier; 2015.

Holloman GH, Jr., Zeller SL. Overview of project BETA: best practices in evaluation and treatment of agitation. The Western Journal of Emergency Medicine [Internet]. 2012 [cited 2019];13(1):1–2.

Jensen L, Clough R. Assessing and treating the patient with acute psychotic disorders. Nursing Clinics of North America [Internet]. 2016 [cited 2019];51(2):185–97.

Kleissl-Muir S, Raymond A, Rahman MA. Analysis of patient related violence in a regional emergency department in Victoria, Australia. Australasian Emergency Care [Internet]. 2019 [cited 2019];22(2):126–31.

Knott JC, Bennett D, Rawet J, Taylor DM. Epidemiology of unarmed threats in the emergency department. Emergency Medicine Australasia [Internet]. 2005 [cited 2019];17(4):351–8.

Knott J, Gerdtz M, Dobson S, Daniel C, Graudins A, Mitra B, et al. Restrictive Interventions in Emergency Departments: A Review of Current Clinical Practice [Internet]. Melbourne: Department of Health and Human Services; 2019 [cited 2020]. 29pp. Available from: https://www2.health.vic.gov.au/about/publications/researchandreports/restrictive-interventions-emergency-departments-review

Luck L, Jackson D, Usher K. STAMP: components of observable behaviour that indicate potential for patient violence in emergency departments. Journal of Advanced Nursing [Internet]. 2007 [cited 2019];59(1):11–19.

Lagomasino I, Daly R, Stoudemire A. Medical assessment of patients presenting with psychiatric symptoms in the emergency setting. Psychiatric Clinics of North America [Internet]. 1999 [cited 2019];22(4):819–50.

Lim M, Weiland T, Gerdtz M, Dent A. Expectations of care, perceived safety, and anxiety following acute behavioural disturbance in the emergency department. Emergency Medicine International [Internet]. 2011 [cited 2019];2011:165738.

Lindenmayer JP. The pathophysiology of agitation. Journal of Clinical Psychiatry [Internet]. 2000 [cited 2019];61 Suppl 14:5–10.

McCoy C, Johnson K. Behavioral emergencies: a closer look. Journal of Emergency Nursing [Internet]. 2011 [cited 2019];37(1):104–8.

McKenna B, Furness T, Oakes J, Brown S. Police and mental health clinician partnership in response to mental health crisis: a qualitative study. International Journal of Mental Health Nursing [Internet]. 2015 [cited 2019];24(5):386–93.

Molyneaux E, Turner A, Candy B, Landau S, Johnson S, Lloyd-Evans B. Crisis-planning interventions for people with psychotic illness or bipolar disorder: systematic review and meta-analyses. BJPsych Open [Internet]. 2019 [cited 2019];5(4):e53.

Niedermier J, Kasick D. Maintaining personal safety: understanding and addressing aggression and violence in the health care setting [Internet]. MedEdPORTAL [Internet]. 2018 [cited 2019];14:10722.

Nordstrom K, Zun LS, Wilson MP, Stiebel V, Ng AT, Bregman B, et al. Medical evaluation and triage of the agitated patient: consensus statement of the American Association for Emergency Psychiatry project BETA medical evaluation workgroup. The Western Journal of Emergency Medicine [Internet]. 2012 [cited 2019];13(1):3–10.

Phillips S. Countering workplace aggression: an urban tertiary care institutional exemplar. Nursing Administration Quarterly [Internet]. 2007 [cited 2019];31(3):209–18.

Ryan CJ, Callaghan S. The impact on clinical practice of the 2015 reforms to the New South Wales Mental Health Act. Australasian Psychiatry [Internet]. 2017 [cited 2019];25(1):43–7.

Smart D, Pollard C, Walpole B. Mental health triage in emergency medicine. Australian and New Zealand Journal of Psychiatry [Internet]. 1999 [cited 2019];33(1):57–66.

Sood TR, McStay CM. Evaluation of the psychiatric patient. Emergency Medicine Clinics of North America [Internet]. 2009 [cited 2019];27(4):669–83.

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Tucci V, Siever K, Matorin A, Moukaddam N. Down the rabbit hole: emergency department medical clearance of patients with psychiatric or behavioral emergencies. Emergency Medicine Clinics of North America [Internet]. 2015 [cited 2019];33(4):721–37.

Tucci VT, Moukaddam N, Alam A, Rachal J. Emergency department medical clearance of patients with psychiatric or behavioral emergencies, part 1. Psychiatric Clinics of North America [Internet]. 2017 [cited 2019];40(3):411–23.

Wong AH, Wing L, Weiss B, Gang M. Coordinating a team response to behavioral emergencies in the emergency department: a simulation-enhanced interprofessional curriculum. The Western Journal of Emergency Medicine [Internet]. 2015 [cited 2019];16(6):859–65.

Zeller SL, Holloman Jr GH, Wilson MP. Management of agitation. In: Tasman A, Kay J, Lieberman JA, First MB, Riba MB, editors. Psychiatry. 2015: 2479–86.

Zeller SL, Rhoades RW. Systematic reviews of assessment measures and pharmacologic treatments for agitation. Clinical Therapeutics [Internet]. 2010 [cited 2019];32(3):403–25.

Transition from prehospital care

Table A3: Level of evidence summary: transition from prehospital care section

	Level I	Level II	Level III-1	Level III-2	Level III-3	Level IV	Level V	Consensus	N/A
Total number	0	0	0	0	0	0	1	0	1

Australian Commission on Safety and Quality in Health Care [Internet]. Sydney: ACSQHC; 2017. Communication at clinical handover; 2019 [cited 2019]. Available from: https://www.safetyandquality.gov.au/standards/nsqhs-standards/communicating-safety-standard/communication-clinical-handover

Australian Charter of Healthcare Rights [Internet]. 2nd edn. Sydney: ACSQHC; 2019. 1 p. Available from: https://www.safetyandquality.gov.au/your-rights

De-escalation

Table A4: Level of evidence summary: de-escalation section

	Level I	Level II	Level III-1	Level III-2	Level III-3	Level IV	Level V	Consensus	N/A
Total number	5	0	0	0	2	0	7	8	0

D'Ettorre G, Pellicani V, Mazzotta M, Vullo A. Preventing and managing workplace violence against healthcare workers in emergency departments. Acta Bio-Medica: Atenei Parmensis [Internet]. 2018 [cited 2019];89(4–S):28–36.

Deal N, Hong M, Matorin A, Shah AA. Stabilization and management of the acutely agitated or psychotic patient. Emergency Medicine Clinics of North America [Internet]. 2015 [cited 2019];33(4):739–52.

Du M, Wang X, Yin S, Shu W, Hao R, Zhao S, et al. De-escalation techniques for psychosis-induced aggression or agitation. Cochrane Database of Systematic Reviews [Internet]. 2017 [cited 2019];(4).

Edward K, Giandinoto J-A, Weiland TJ, Hutton J, Reel S. Brief interventions to de-escalate disturbances in emergency departments. British Journal of Nursing [Internet]. 2018 [cited 2019];27(6):322–7.

Gaynes BN, Brown CL, Lux LJ, Brownley KA, Van Dorn RA, Edlund MJ, et al. Preventing and de-escalating aggressive behavior among adult psychiatric patients: a systematic review of the evidence. Psychiatric Services [Internet]. 2017 [cited 2019];(8):819.

Hallett N. Preventing and managing challenging behaviour. Nursing standard [Internet]. 2018 [cited 2019];(26):51.

Harwood, RH. How to deal with violent and aggressive patients in acute medical settings. The Journal of the Royal College of Physicians of Edinburgh [Internet]. 2017 [cited 2019];(2):176.

Knott J, Gerdtz M, Dobson S, Daniel C, Graudins A, Mitra B, et al. Restrictive Interventions in Emergency Departments: A Review of Current Clinical Practice [Internet]. Melbourne: Department of Health and Human Services; 2019 [cited 2020]. 29pp. Available from: https://www2.health.vic.gov.au/about/publications/researchandreports/restrictive-interventions-emergency-departments-review

Richmond JS, Berlin JS, Fishkind AB, Holloman GH, Zeller SL, Wilson MP, et al. Verbal de-escalation of the agitated patient: consensus statement of the American Association for Emergency Psychiatry project BETA de-escalation workgroup. The Western Journal of Emergency Medicine [Internet]. 2012 [cited 2019];(1):17.

Lavelle M, Stewart D, James K, Richardson M, Renwick L, Brennan G, et al. Predictors of effective de-escalation in acute inpatient psychiatric settings. Journal of Clinical Nursing [Internet]. 2016;25(15-16):2180–8.

McGonigle JJ, Venkat A, Beresford C, Campbell TP, Gabriels RL. Management of agitation in individuals with autism spectrum disorders in the emergency department. Child and Adolescent Psychiatric Clinics of North America [Internet]. 2014 [cited 2019];23(1):83–95.

Miner JR, Klein LR, Driver B, Minder ID, Cole JB, West JR. Success rate of verbal de-escalation in the treatment of agitated patients in the emergency department in SAEM annual meeting abstracts. Academic Emergency Medicine [Internet]. 2019 [cited 2019];26(S1):S172.

Mitra B, Nikathil S, Gocentas R, Symons E, O'Reilly G, Olaussen A. Security interventions for workplace violence in the emergency department. Emergency Medicine Australasia [Internet]. 2018 [cited 2019];(6):802.

New A, Tucci VT, Rios J. A modern-day fight club? The stabilization and management of acutely agitated patients in the emergency department. Psychiatric Clinics of North America [Internet]. 2017 [cited 2019];40(3):397–410.

Raveel A, Schoenmakers B. Interventions to prevent aggression against doctors: a systematic review. BMJ Open [Internet]. 2019 [cited 2019];9(9):e028465.

Roberton T, Daffern M, Thomas S, Martin T. De-escalation and limit-setting in forensic mental health units. Journal of Forensic Nursing [Internet]. 2012 [cited 2019];8(2):94–101.

Spencer S, Johnson P, Smith IC. De-escalation techniques for managing non-psychosis induced aggression in adults. Cochrane Database of Systematic Reviews [Internet]. 2018 [cited 2019];(7).

The Joint Commission Division of Healthcare Improvement. Quick Safety 47: de-escalation in health care [internet]. Washington, DC: The Joint Commission; 2019 [cited 2019]. 5p. Available from: https://www.jointcommission.org/assets/1/23/QS_Deescalation_1_28_18_FINAL.pdf

Touzet S, Occelli P, Denis A, Cornut PL, Fassier JB, Le Pogam MA, et al. Impact of a comprehensive prevention programme aimed at reducing incivility and verbal violence against healthcare workers in a French ophthalmic emergency department: an interrupted time-series study. BMJ Open [Internet]. 2019 [cited 2019];9(9):e031054.

Victorian Government Department of Health and Human Services. Code grey standards [Internet]. Melbourne: Department of Health and Human Services. Available from: https://www2.health.vic.gov.au/health-workforce/worker-health-wellbeing/occupational-violence-aggression/code-grey-black

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Victorian Government Department of Health and Human Services. Safewards handbook [Internet]. Melbourne: Department of Health and Human Services. Available from: https://www2.health.vic.gov.au/mental-health/practice-and-service-quality/safety/safewards/training-resources

Weiland T, Ivory S, Hutton J. Managing acute behavioural disturbances in the emergency department using the environment, policies and practices: a systematic review. The Western Journal of Emergency Medicine [Internet]. 2017 [cited 2019];18(4):647–61.

Sedation and ongoing care post-sedation

Table A5: Level of evidence summary: sedation and ongoing care post-sedation section

	Level I	Level II	Level III-1	Level III-2	Level III-3	Level IV	Level V	Consensus	N/A
Total number	1	6	0	6	1	4	0	6	0

ACEM, ANZCA, CICM, RANZCP. Guidelines for safe care for patients sedated in health care facilities for acute behavioural disturbance [Internet]. Melbourne: ANZCA; 2018 [cited 2019]. Available from: http://www.anzca.edu.au/documents/ps63-2018-guidelines-for-safe-care-for-patients-se.pdf

Barbic D, Andolfatto G, Grunau B, Scheuermeyer FX, MacEwan W, Honer WG, et al. Rapid agitation control with ketamine in the emergency department (RACKED): a randomised controlled clinical trial protocol. Trials [Internet]. 2018 [cited 2019];19(1):651.

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Calver L, Page CB, Downes MA, Chan B, Kinnear F, Wheatley L, et al. The safety and effectiveness of droperidol for sedation of acute behavioral disturbance in the emergency department. Annals of Emergency Medicine [Internet]. 2015 [cited 2019];66(3):230–8.

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Castle D, Chan E, Karro J, Knott, J Kong D, Phillips G, et al. Midazolam-droperidol, droperidol, or olanzapine for acute agitation: a randomized clinical trial. Annals of Emergency Medicine [Internet]. 2017 Mar [cited 2019];69(3):318–26.

Chan EW, Taylor DM, Knott JC, Phillips GA, Castle DJ, Kong DCM. Intravenous droperidol or olanzapine as an adjunct to midazolam for the acutely agitated patient: a multicenter, randomized, double-blind, placebo-controlled clinical trial. Annals of Emergency Medicine [Internet]. 2013 [cited 2019];61(1):72–81.

Cohen S, Bhatia A, Buvanendran A, Schwenk E, Wasan A, Hurley R et al. Consensus guidelines on the use of intravenous ketamine infusions for chronic pain from the American Society of Regional Anesthesia and Pain Medicine, the American Academy of Pain Medicine, and the American Society of Anesthesiologists. Regional Anesthesia and Pain Medicine [Internet]. 2018 [cited 2019];43(5):521–46.

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Khokhar M, Rathbone J. Droperidol for psychosis-induced aggression or agitation. Cochrane Database of Systematic Reviews [Internet]. 2016 [cited 2019];12.

Knott JC, Taylor DM, Castle DJ. Randomized clinical trial comparing intravenous midazolam and droperidol for sedation of the acutely agitated patient in the emergency department. Annals of Emergency Medicine [Internet]. 2006 [cited 2019];47(1):61–7.

Le Cong M, Ellis D, Finn E, Hill M, Johnson R, Langford S, Parsch C, Setchell J. The acutely agitated patient in a remote location assessment and management guidelines a consensus statement by Australian aeromedical retrieval services [internet]. 2015.

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Murray L, Little M, Pascu O, Hoggett K. Toxicology handbook. Chatswood: Elsevier; 2015.

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Physical and mechanical restraint and ongoing care while restrained

Table A6: Level of evidence summary: physical and mechanical restraint and ongoing care while restrained section

	Level I	Level II	Level III-1	Level III-2	Level III-3	Level IV	Level V	Consensus	N/A
Total number	3	0	0	2	10	1	12	4	0

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Transition from the emergency care setting

Table A7: Level of evidence summary: transition from emergency care setting section

	Level I	Level II	Level III-1	Level III-2	Level III-3	Level IV	Level V	Consensus	N/A
Total number	0	0	0	0	0	0	1	0	1

Australian Commission on Safety and Quality in Health Care [Internet]. Sydney: ACSQHC; 2017. Communication at clinical handover; 2019 [cited 2019 Dec]. Available from: https://www.safetyandquality.gov.au/standards/nsqhs-standards/communicating-safety-standard/communication-clinical-handover

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Staff support and case review

Table A8: Level of evidence summary: staff support and case review section

	Level I	Level II	Level III-1	Level III-2	Level III-3	Level IV	Level V	Consensus	N/A
Total number	0	0	0	0	0	0	2	4	1

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Appendix 2: Public consultation report

We asked for your view on Safer Care Victoria's (SCV) clinical guidance on caring for people displaying acute behavioural disturbance in emergency settings. This new clinical guidance aims to support emergency clinicians to provide person-centred, evidence-based care. With your help we have finalised the guidance, now available at safercare.vic.gov.au

PURPOSE

Improving the care of people displaying acute behavioural disturbance is a priority focus area for SCV's Emergency Care Clinical Network. With the help of experts including clinicians and healthcare consumers we produced some new clinical guidance to support person-centred, evidence-base care.

We invited feedback from the public to help us make sure our guidance was practical, appropriate and useful.

This summary includes public consultation key insights and themes, as well as how public feedback helped us shape the final guidance.

HOW WE ENGAGED

The draft clinical guidance, visual summary, and supplement outlining our development method and supporting evidence was available for public consultation over a four-week period in February 2020. Feedback was invited through an electronic survey.

We received 68 online contributions through the electronic survey and five direct email submissions.

WHO PROVIDED FEEDBACK

Seventy per cent of responses were from individuals, most of whom were nurses (**Figure 1**). The remaining 30 per cent of responses were from a variety of groups (**Figure 2**).

Figure 1: What best describes your role?

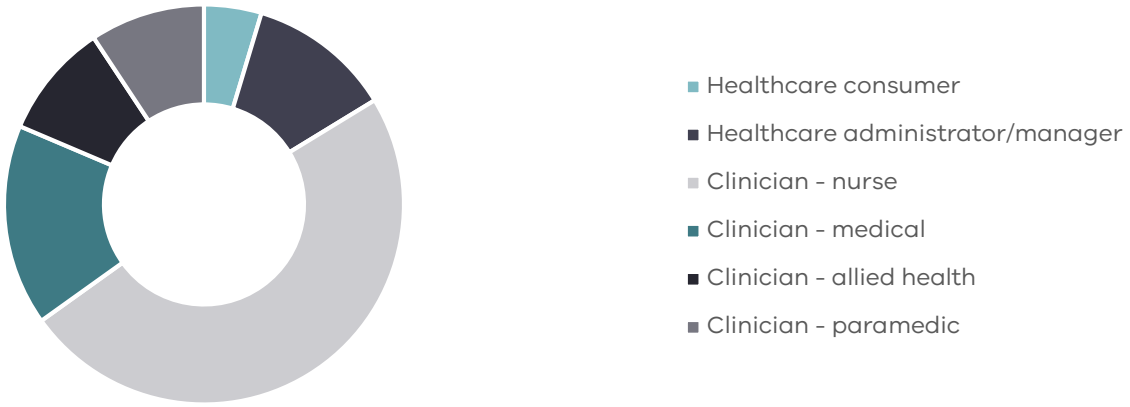
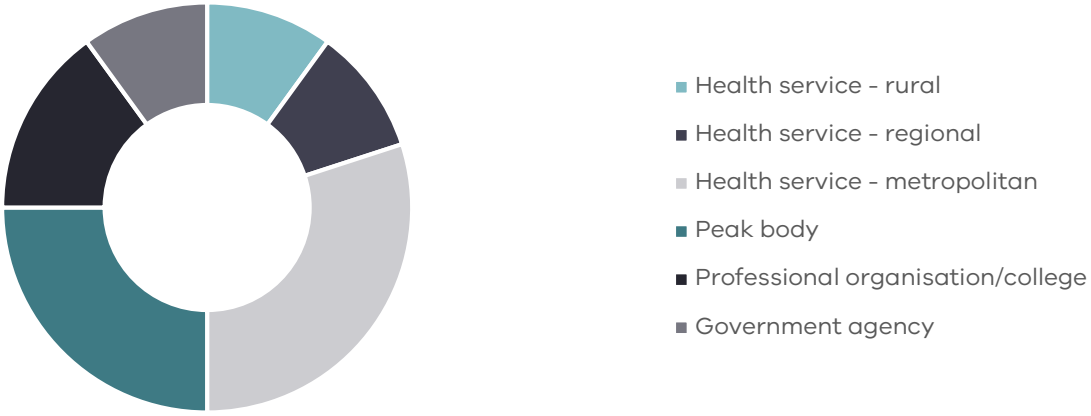


Figure 2: What best describes your group?



WHAT YOU TOLD US

Your responses to our public consultation questions, key insights and how they shaped the final guidance are summarised in **Table 1**.

There was very positive sentiment towards the wording, language and structure of the guidance. We made only slight adjustments to the wording.

Of 20 respondents who said we had not considered all relevant and important evidence, three provided additional evidence. We reviewed this evidence and it is now included in our bibliography.

Respondents made several suggestions for how the care we recommend could be more appropriate and acceptable. The summary in Table 1 is not exhaustive.

There was also positive sentiment towards our visual summary, and we used this feedback to help us refine the design.

Table 9: Public consultation question responses and key insights

Consultation question	Responded yes	What you told us	How this shaped the final guidance
Is the wording respectful to healthcare consumers, healthcare staff and the public?	92%	The wording could demonstrate deeper understanding of people with intellectual disabilities such as autism	Adjusted language to reflect that people with intellectual disabilities usually only display acute behavioural disturbance when there is an underlying cause
Is the guidance easy to read and understand?	91%	The structure and language is easy to understand	No significant adjustments to structure or language

Consultation question	Responded yes	What you told us	How this shaped the final guidance
Has the guidance considered all relevant and important evidence that you know of?	69%	There are several helpful existing resources you could link to	Added links to DHHS resources on code grey, weapons management and staff support
Does the guidance recommend care that you consider appropriate and acceptable?	77%	Nicotine withdrawal is a common cause of acute behavioural disturbance The intent of section 7 is not clear. It does not distinguish between psychological and operational review You have missed opportunities to integrate with existing health service resources	Added nicotine withdrawal to Table 3 and emphasised importance of early treatment Renamed section 7. Restructured section to reflect differences between staff support and case review Added references to health services' individual code grey responses and incident management systems
Is the visual summary clear and easy to follow?	89%	The colours make the visual summary hard to use. It is a bit cluttered	Changed the colours. De-cluttered and refined the design
Does the visual summary accurately reflect the contents of the guidance?	95%	The visual summary could highlight the importance of staff safety and repeated assessment	Added graphic prompts to highlight staff safety and ongoing/repeated assessment

Safer Care
Victoria